APPLICATION FOR COMMUNITY RESIDENTIAL SERVICES

ND DEPARTMENT OF HUMAN SERVICES
MENTAL HEALTH AND SUBSTANCE ABUSE
SFN 1005 (Rev. 01-2002)

FOR CENTER USE
Date Received:
Case Number:
Disposition:

Name of Applicant:
Name of Human Service Center:

HOUSING OPTION WHICH IS BEING APPLIED FOR:	
Transitional Living	☐
Supportive Apartment	☐
Long-Term Care	☐
Other (Specify)	☐

IDENTIFYING DATA

Name:			Birthdate:
Address:			Sex:
City:	State:	Zip:	Race:
Telephone:			Occupation:
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other			Education Level: (Check One) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20

DIAGNOSIS

Axis 1:
Axis 1:
Axis 1:
Axis 2:
Axis 2:
Axis 3:
Axis 3:
Axis 3:
Axis 4:
G.A.F./Axis 5:
Patient Strengths:
Patient Primary Problem:
Patient Secondary Problem:
Other Problem:

Suicide Risk:	Date of Last:
History Of:	
Violence Risk:	Date of Last:
History Of:	

PRESENTATION

Appearance:	☐ Well groomed	☐ Unkempt	☐ Unusual	☐ Bizarre			
Mood:	☐ Normal	☐ Depressed	☐ Anxious	☐ Euphoric			
Attitude:	☐ Cooperative	☐ Friendly	☐ Exaggerates Symptoms	☐ Guarded	☐ Minimizes Symptoms		
	☐ Suspicous	☐ Hostile	☐ Uncooperative				
Affect:	☐ Appropriate	☐ Labile	☐ Expansive	☐ Constructed	☐ Flat		
Speech:	☐ Normal	☐ Slow	☐ Too Detailed	☐ Pressured	☐ Incoherent	☐ Perserving	
Motor Activity:	☐ Relaxed and Calm	☐ Restless	☐ Agitated	☐ Tense	☐ Tremors	☐ Tics	
Orientation:	☐ Fully Orientated	☐ Person Disoriented	☐ Place Disoriented	☐ Time Disoriented			
	☐ Person and Place Disoriented	☐ Person and Time Disoriented	☐ Time and Place Disoriented				
	☐ Completely Disoriented						

EMERGENCY INFORMATION

In Case of Emergency, Notify: (Name)		Relationship:		
Address:	City:	State:	Zip Code:	Telephone:

FAMILY DATA

Name of Spouse:		Telephone:		
If Address is Different Then Clients:		City:	State:	Zip Code:
Parent's Name:		Telephone:		
If Address is Different Then Clients:		City:	State:	Zip Code:
CHILDREN: NAME			**AGE**	**SCHOOL GRADE**

FINANCIAL DATA

Gross Income:	Representative Payee:		Telephone:	
Address:		City:	State:	Zip Code:
Income Received From: (Write in Amount)		City:		
SSI:	SSDI:	Wages from Employment:		
Family Support:		Other, Please Specify:		
Blue Cross/Blue Shield No.:		Medical Assistance:		
Insurance Number:	Name of Insurance:		From Which County:	

LEGAL INFORMATION

Please attach a copy of any court order that the client is currently under. Has client ever been accused of any of the following, Spouse Abuse, Child Abuse, Sexual Molestation, etc. If yes, please explain: ☐ Yes ☐ No			
Name of Guardian:			Telephone:
Address:	City:	State:	Zip Code:
Please list past criminal charges and convictions of client below:			
Does patient have any current legal problems? ☐ Yes ☐ No If yes, please explain:			

MEDICAL DATA

List Psychiatric Hospitalizations During Past Two Years:

HOSPITAL	DOCTOR	DATES

Name of Regular Physician;	Telephone:		
Address:	City:	State:	Zip Code:
Hospital of Choice:	Telephone:		
Address:	City:	State:	Zip Code:

Please have nurse complete:

List of Medication (and Dosage):
Client is Now Using. Please include all PRN's and over the counter Medication.

Has this Medication Changed in the last 30 days? ☐ Yes ☐ No If so, What?

Nurse:	Date:

Does the Client Have: **Heart Problems:** ☐ Yes ☐ No **Seizures:** ☐ Yes ☐ No
Allergies: (Drug & Other) _____
Hypertension: ☐ Yes ☐ No **Diabetes:** ☐ Yes ☐ No

Has client been Tuberculosis (TB) tested in the past year? ☐ Yes ☐ No If yes, we need a copy of the results. If no client, needs to be tested prior to entering the Home.

Does client have any sexually transmitted disease, Hepatitis, or any other health issue we should know about?

Other Physical Handicaps or Disabilities: (Please Specify):

VOCATIONAL DATA

List Employment Held:

EMPLOYMENT	DATES

Does the Client Now Hold a Job? ☐ Yes ☐ No If so, What?

Is the Client Unemployed? ☐ Yes ☐ No	If the Client is Unemployed, What Kind of Job Would he/she Prefer?	How Long?

Is the Applicant a client with Vocational Rehabilitation? ☐ Yes ☐ No	If Yes, Name of Counselor:		
Address:	City:	State:	Zip Code:

Has the client ever been in a Residential program before? ☐ Yes ☐ No If yes, please list:

REFERRAL SOURCE

Name:	Telephone:		
Address:	City:	State:	Zip Code:

ENCLOSURES: Please attach the following reports:

☐ Physical Examination ☐ Psychological Evaluation ☐ Current Lab Reports ☐ Social History

Social History should at a minimum include:

☐ Developmental History ☐ Education ☐ Employment ☐ Hospitalization ☐ Presenting Problems

CURRENT ASSESSMENT OF CONDITION AND READINESS FOR COMMUNITY FOR COMMUNITY RESIDENTIAL SERVICES INCLUDING ABILITY FOR SELF-MEDICATION, SELF-HELP SKILLS, EMPLOYMENT AND ETC. AND WHY IS RESIDENTIAL LEVEL OF CARE NEEDED:

Signature of Person Completing Above Statement:

Title:

I HAVE READ THE ABOVE INFORMATION AND I AGREE WITH THE ACCURACY OF THE STATEMENTS MADE.

Signature of Client:	Date: